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Title:

Perceived Job-Anxiety and General Psychosomatic Symptom Load and Perceived Social Support – Is there a Relationship?

Abstract

Objective: Job-related distress has often been found to be related with low social support at work. The question is whether dimensions of social support outside work have a similar relation with job-anxiety or whether they are independent.

Method: A sample of 154 employed inpatients from a psychosomatic rehabilitation center (70% women) completed self-rating questionnaires on perceived symptom load in the domain of work (job-anxiety) and in general life (general psychosomatic symptom load), and on perceived social support at work and outside work.

Results: Job-anxiety showed moderate correlations with the perceived level of social support through colleagues. Thereby the social support dimensions of "consolation and encouragement" and "criticism, overload, rejection" were more strongly related to job-anxiety than the dimension of "practical support". There were no significant correlations between job-anxiety and social support through household members, leisure time partners or neighbors.

Conclusion: Social support is in a specific way important in the context of work other than concerning general mental health outside the work-context. Job-anxiety is a domain-specific clinical phenomenon and independent from perceived social support outside the workplace.

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Keywords

Social support, participation disorders, job-anxiety, anxiety disorders

Introduction

Workplace and mental health

Work and workplaces in general have been found to have both positive and negative effects on health and wellbeing [6, 17, 18]. There are many empirical findings that work demands and stress are related with the development of mental disorders [11, 20, 25, 27, 34]. The organization and structure of workplaces can be anxiety-provoking by its nature (i.e. due to demands of achievements and the possibility of failure), or getting sanctioned by superiors, or rivalries with colleagues [22]. In this context it has been found that social conflicts at work are often associated with workplace-related (social) anxieties [21, 28].

Workplaces and (social) anxiety

Workplaces can provoke (social) anxiety in different ways:

Feeling threatened by superiors. Workplaces are usually structured hierarchically, which means people often have superiors or managers to whom they report. The task of superiors/managers is to instruct and supervise workers, and therefore also to reward or to punish them. That is why superiors are a potential anxiety provoking factor by the nature of their roles.

In the literature one can find encouraging hints addressed to the management of companies to establish a working atmosphere that makes it possible to discuss disagreements, including between different levels of the hierarchy. Perlow and Williams [31] conclude that “breaking the silence can bring an outpouring of fresh ideas from all levels of an organization – ideas

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might just raise the organization's performance to a whole new level" (p.52).

Career and social hierarchy. Colleagues can be especially threatening. Human beings live in groups; there is no formation of a human group without the development of hierarchy. This is especially the case for those who are in neighboring ranked positions, such as who is going to be promoted, who gets the bigger room, who has to carry out the disliked job, and so on. In this context, "The darker side of groups" has been mentioned by Thomas and Hynes [36]. The authors focus on the role of group interaction in the workplace: the impact on anxiety and group cohesion and on how the manager may recognize negative signs in order to prevent possible social conflicts. However, in contrast to the possible negative processes that may develop in social interaction at the workplace, there are also warnings concerning the loss of personal face-to-face-interactions at work [16]: while email-communication increases, there is also the risk of social isolation, which may cause irritation and misunderstandings.

Social conflicts, mobbing. People often live together at their workplace in a small space, such as in an office. They pass most of their daytime together there, perhaps more than with their families at home. Therefore it is no wonder that workplace social conflicts also occur: people like or dislike each other, they support or do not support each other. When there are conflicts and arguments at work, there is often no possibility to avoid these, because they occur in structured and obligatory interaction situations, for example team conferences, or in the office shared with several colleagues. Being confronted with a disliked colleague or superior every day in recurring situations makes conflicts in professional setting in a special way durable and problematic.

Patients treated in psychosomatic rehabilitation for mental health concerns often report that they had been bullied by colleagues or superiors at their workplace. There have been studies

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on the relationship between mental health and bullying at work [2], which found the poorest scores on anxiety and depression scales in persons who reported being bullied at work. Girardi and colleagues [13] have studied personality and psychopathological profiles in individuals exposed to mobbing and found two major dimensions: first, a passive-aggressive trait, with depressed mood and difficulty in making decisions, and second a combination of somatic symptoms and need for attention and affection. The relationship between dysfunctional workplace organizations and mobbing was pointed out in case studies by Albini et al. [1]. Yildirim and Yildirim [42] carried out an investigation in health care nurses exposed to mobbing and found that the most common behaviors exhibited by the participants to escape mobbing were to work harder and be more organized and to work more carefully to avoid criticism. A small number even stated that they considered committing suicide at times.

Workplaces and Social Support

Taking into consideration these special social and interactional conditions that characterize workplaces – namely hierarchies, reward and sanctioning, formal, structured and obligatory interaction situations, impossibility of avoiding certain disliked persons - empirical research has shown that employees who perceived sufficient social support reported work-related distress less frequently than people who did not feel socially supported [9, 26].

Several studies [30, 40] have found that social support through colleagues and especially through superiors [12, 35] can help to reduce work stress, whereas social support in other domains of life – such as the worker's partner [37] – was independent from perceived work stress.

Research studies carried out in different professional settings [27, 29, 38, 39] have found that low social support at work leads to increased rates and duration of absence. Higher social

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support is related to less frequent changes of the workplace and less frequent loss of the workplace [19]. Findings from a meta-analysis [7] support the relationship between interpersonal conflicts, team achievements and team satisfaction.

However, although social support seems to be a resource for coping with stress, there is also evidence that social support can also be counterproductive [14]. Other studies point out that visible social support can be distinguished from invisible support [3, 4]. Visible social support can entail an emotional cost. A social supportive act is most effective when it is accomplished either outside of recipients' awareness or within their awareness but with sufficient subtlety that they do not interpret it as support.

Finally, it must be kept in mind that the perception of social support is always connected with certain basic attitudes. Brisette, Scheier, and Carver [5] suggested a model in which increases in social support and greater use of positive reinterpretation and growth contributed to superior adjustment during a life transition. There are always interactions between personal as well as context-specific factors which play a role for the perception of visible social support as actually “supportive” [32].

Summarizing, literature shows that social support is an important variable when discussing coping with stress and mental health. The workplace is a specific area of life, and when discussing coping with stress *at work* also social support *at work* is regarded specifically.

Concerning symptom load related to the workplace, an assumption could be that the more *positive social support* a person perceives, the less he or she perceives specific *job-anxiety* [12, 35, 30, 40]. The question however, is whether this is true

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for both *social support outside work* and *social support at work*, or whether there are differences concerning these different social support dimensions in relation to perceived symptom load.

Objective

The aim of this study is to investigate whether groups of patients with different levels of perceived job-anxiety show differences in their perceived social support at work and their perceived social support outside work.

Therefore, in this study the meaning of

- dimensions of social support at work and
- dimensions of social support outside work

is investigated and related to the perceived job-anxiety level of patients with psychosomatic and mental health problems.

A sample of psychosomatic rehabilitation inpatients is used in this investigation.

The patients are usually suffering from general mental disorders (including anxiety disorders), but a great number of them is additionally affected from specific workplace-related problems. These patients usually report specific workplace-related anxieties. In some of the patients even a workplace-related anxiety is the primary mental health problem [21, 22].

Such a sample with mixed mental health problems - i.e. workplace-related and/or general mental health problems - is especially suited for an investigation which focuses on differences between the workplace-domain and the domain outside the workplace. In such a sample, the relations between “job-anxiety” and “general psychosomatic symptom load” and “social support at work” and “social support outside work” can be investigated best [21].

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Method

Study Design

This study used a cross-sectional design in a clinical population, namely patients admitted to an inpatient psychosomatic rehabilitation treatment. This population is especially suited for an investigation on work-related problems and mental symptom load.

Patients admitted into the clinic were given an information sheet about the study titled "Workplace problems and mental health" on the day of arrival. The day after admission they were invited to participate via a personal phone call. The study was anonymous and participants were free to participate or not after having been informed that their answers were used for scientific purposes only. Inclusionary criteria for participation in the study were being aged between 20-65 years (i.e. patients of working age). Patients who agreed to participate completed questionnaires on general psychosomatic symptom load and job-anxiety, as well as on social support.

Additionally, data from the routine admission interview were used (i.e. data on sick leave duration and sick leave status at admission).

Clinical setting

In this clinical setting, patients are admitted because their mental illness has taken a chronic course (e.g. persistent anxiety disorders or recurring depression), or has caused prolonged periods of sick leave. Psychosomatic patients stay in the clinic on average for six weeks. The program consists of single- and group-psychotherapy which are carried out by medical practitioners and psychologist psychotherapists in co-operation with sport-therapists, social workers and ergo-therapists (also known as occupational therapists). In the context of the

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individual management of workplace problems and in view of professional reintegration there are, if necessary, intensified contacts with social workers, practical work-experience at real workplaces outside the clinic, and additional group therapies concerning time management, management of social conflicts at the workplace and job application training.

Participants

The participation rate in this study was high; 92% of invited patients from a psychosomatic rehabilitation clinic took part in the study. Twenty eight percent of patients were unemployed at the time of the study, which is representative for a psychosomatic inpatient population in this clinic. Those patients who were unemployed were excluded from this analysis, because they were not able to provide data on presently perceived social support through colleagues at work.

Finally, data of 154 employed inpatients were analyzed in this study. The greater part of the analyzed sample (70.1%) were women. The average age was 46.9 years (*SD* = 8.8, range: 21 – 64 years). All patients from whom data were analyzed in this study were employed at the time of admission; 90.3% were employed as white-collar-workers, 3.7% had a high qualified leading position, 3% were self-employed, and 3% were working as blue-collar (or unskilled) workers. Patients were employed in different professional domains: 17.9% were employed in the domain of technology, manufacturing and production, 13.6% in the practical health care domain, 11.7% in education and culture, 30.9% in public services, 25.9% in public administration and office jobs.

Concerning their partner situations, 60.2% were living with a partner, 34.4% without a partner, and 3.7% in other households.

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Instruments

The *Job-Anxiety Scale* (JAS) [23, 28] is a self-rating scale designed to measure different dimensions of job-anxiety. It has 70 items covering five main dimensions: *Stimulus-related anxieties and avoidance behavior* include anticipatory anxieties with feelings of strain when being at the workplace or in anticipation of situations or events at the workplace, phobic avoidance of work situations, conditioned or posttraumatic anxiety, global feelings of anxiety toward the workplace. The dimension of *Social anxieties* includes interactional anxiety (i.e. fears when confronted with colleagues or superiors, ideas of persecution and mobbing and fears of exploitation). *Health related anxieties* include hypochondriac anxieties and the idea that working conditions endanger health, experience of panic or other somatic symptoms while being at work, and functional impairment (i.e. the fear that one's own ill health impairs work performance). *Cognitions of insufficiency* mean the feeling of insufficient qualification, overload, or lack in knowledge, and fear of change or feelings of insecurity because of impending changes at the workplace. *Job-related worries* describe generalized worrying about minor matters concerning the workplace, as well as worries about the job security and future. The five dimensions have been derived by factor analysis. The items are rated on a Likert-scale: "0 = no agreement" to "4 = full agreement". Retest reliability is .815, Cronbach´s alpha .98 [23]. The scale has been validated with an interview on workplace-related anxieties as the criterion [21]. The *Job-Anxiety-Scale* is given to patients with the title "A questionnaire on workplace-related problems" that examines "situations, thoughts and feelings one can experience at the workplace". The mean score of the JAS can be interpreted as a measure for an overall job-anxiety degree.

The *Symptom Checklist* in revised version (SCL-90-R) [8, 10] is a self-rating questionnaire that measures general psychosomatic symptom load within a period of seven days. The

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questionnaire explores symptom load on different subscales: somatization, compulsiveness, anxiety in social contacts, depressive tendencies, general anxiety, aggressiveness, phobic anxiety, paranoid thinking and psychotizism. Participants give ratings on 90 items on a scale from 0 (never occurring) to 4 (occurring frequently).

The *Multidimensional Social Support Questionnaire* (origin: Multidimensionaler Sozialkontakt-Kreis, MuSK) [24] is a self-rating questionnaire containing 18 items. It explores the degree of social support a person perceives in six domains of everyday life: through household members, the wider family, through friends, leisure time partners, neighbors and colleagues at work. For each domain participants give ratings to which degree (0-4) they feel

1. supported practically
2. supported emotionally
3. criticized and rejected

by these persons in their social network. Rating was done on five-step Likert scales. Retest-reliability was tested in a clinical population; it was between .41 and .98. [24]. Analysis will be done for each item of the six domains.

Additionally, patients were asked for a rating to which degree on a scale from 0-100 their workplace situation was a burden for their current health status. This rating functions as an indicator for perceived "work load".

Data analysis

Data were analyzed with SPSS-PC version 12.0. T-Tests for independent samples were used to investigate mean differences of interval variables. All statistical tests were two-tailed and

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the alpha-level of significance was set at $p<.05$.

Results

Patients were grouped according to their level of job-anxiety: low, moderate, higher and strongest level of job-anxiety. About one third of the sample (31.1%) reported higher or strongest levels of job-anxiety. More than two thirds (66-84%) of these patients were on sick leave at the time of admission (Table 1).

[Insert table 1 about here]

The higher the perceived level of job-anxiety, the more participants were convinced that the workplace caused or forced their health problems: Patients with higher and strongest job-anxiety level had higher levels on their "work load" rating (on average 60.0 and 83.9). Compared to patients with low or moderate job-anxiety levels, patients with higher and stronger levels of job-anxiety had more severe work-participation problems: Most of them (66% and 84%) were on sick leave before admission. They also were significantly longer on sick leave before admission to rehabilitation, and they had longer sick leave durations during the past 12 months (on average 18.8 and 27.8 weeks; Table 1) than patients with low or moderate job-anxiety levels (5.7 and 9.9 weeks; $p=.000$, $p=015$).

The four groups of patients with different levels of job-anxiety were investigated concerning differences in social support perception (Table 1). Here it can be seen that only in the domain of work there were consistent significant relationships between the degrees of perceived social support and level of job-anxiety: for the items "practical support" and "consolation and

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encouragement" in the social support domain "colleagues at work", patients with low job-anxiety had significantly lower scores than those patients with strongest job-anxiety; while in the item "criticism, overload, rejection" they scored significantly higher.
However, in nearly all the dimensions of social support outside work - namely "household", "wider family", "leisure time contacts", "neighbors" - there were no differences between patients with strongest job-anxiety and those with low job-anxiety (Table 1). In the social support dimension of "friends", patients with low and strongest job-anxiety levels showed significant differences only in the item "consolation and encouragement".

As the general psychosomatic symptom load and job-anxiety were found to be related to a moderate degree, partial correlations were calculated in order to identify the degree of correlations of each of the two parameters when cleared from the influence of the other parameter (Table 2).

[insert table 2 about here]

The more patients perceived "criticism, overload, rejection" from colleagues, and the less they perceived "consolation and encouragement" and thus emotional support, the higher was their job-anxiety level. There were no significant and consistent relationships between job-anxiety and social support in the domains of "household", "wider family", "leisure time contacts", "friends" and "neighbors".

"Criticism, overload, rejection" through friends remained as a factor moderately related to the degree of general psychosomatic symptom load (GSI). Other than this, there were no significant correlations between the general psychosomatic symptom load and perceived

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social support.

Discussion

Workplace-related distress and mental health problems have often been found to be related with low social support at work. This study was focusing on the question whether dimensions of social support *outside* work have a similar relation with job-anxiety or whether they are independent.

In a sample of employed psychosomatic rehabilitation inpatients, job-anxiety was found to be correlated with the perceived level of social support through colleagues. There were no significant correlations between job-anxiety and social support through household members, leisure time partners or neighbors.

In the following, the results on the relationship between symptom load and social support will be discussed. The specific meaning of job-anxiety will be regarded. Limitations of the study and implications for future research and clinical practice will be discussed in the end.

Relationships between symptom load and social support

There were no consistent relationships between the symptom load and different domains of social support outside work. On the first view this seems to be contrary to many findings in the literature, which point out the positive effect of social support on wellbeing: for example, it was found that low/poor social support was related to increased morbidity, and shortened life duration [40]. Social support can function as a buffer between stressor and state of health [11]. But it has also been found that social support in specific contexts can also be problematic: for example, Gleason et al. [14] found that receiving daily support was associated with greater feelings of closeness, but also greater negative mood. Regarding these

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aspects, the results of this investigation may speak for the existence of both positive and negative relations between diverse forms of perceived social support and mental health.

Furthermore, the heterogeneity of components of a social network must be considered [24]. This may also contribute to the result of obvious independence between general psychosomatic symptom load and the diverse dimensions of social support outside work. In private life, there are usually a number of possibilities to feel either supported or stressed by friends, family, neighbors, household members and so on. One person, for example, may perceive the family as a stressor, but friendship contacts as supporting. For another person, it may be the other way round. That could be an explanation why there cannot be found consistent specific relations between general wellbeing and social support through the family, or friends, or neighbors and so on. In contrast, concerning the domain of workplace, there must be definitively a relation between perceived supportive interactions with work colleagues and personal work-related wellbeing (for which the level of job-anxiety is one marker), because there are no alternative supportive social resources in this specific place and domain of life.

Another important aspect that may explain the non-relatedness between most of the social supportive domains and general or job-related symptom load is the phenomenon of implicit social support. Bolger et al. [4] mentioned the importance of invisible social support. They showed that invisible support transactions promote adjustment to a major stressor. It was also pointed out [3] that visible social support can entail an emotional cost, and that a supportive act is most effective when it is accomplished either outside of recipients' awareness or within their awareness, but with sufficient subtlety that they do not interpret it as support. In their study on the influence of social support on adjustment to stress the authors found that visible

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support, in contrast to invisible, was either ineffective or it exacerbated reactivity. However, invisible social support is difficult to operationalize in a self-rating questionnaire and it cannot be asked for explicitly.

The specific meaning of job-anxiety

The most important result of this study is that job-anxiety did not show significant relationships with any of the dimensions of social support outside work, but with "social support through colleagues". This speaks for the validity and domain-specificity of job-anxiety in comparison to general psychosomatic symptom load. Job-anxiety has its own clinical value and cannot be subsumed under "general psychosomatic symptom load".

Patients with low and patients with strongest levels of perceived job-anxiety had differences in their perceived social support at work, but not in perceived social support outside work. Therefore both work-specific concepts "job-anxiety" as well as "social support at work" seem to be specific concepts, and thus cannot equated with "general psychosomatic symptom load" or "social support in general".

These results support findings from other studies on workplace-related anxieties and mental disorders in which it was found that workplace-related anxieties and conventional anxiety disorders can be distinguished one from the other in a structured interview [21, 33]. Mental health thus cannot be seen "in general": Patients refer to the context in which symptoms have importance or occur, and they differentiate between workplace-related and other mental syndromes. The specificity of job-anxiety can be explained by the specific context conditions that characterize workplaces (see introduction).

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The results concerning the specificity of job-anxiety also fit to what has been found in earlier research studies that investigated the domain of work: These also operationalized social support explicitly as domain-specific, namely work-related social support and referred to colleagues and superiors [7, 12, 27, 29, 30, 35, 37, 38, 39, 40].

Dimensions of social support

The finding that "criticism, overload, rejection" and "consolation and encouragement" through colleagues are more narrowly related to job-anxiety than deficits in "practical support" show that dimensions of interactional and emotional social support may be more important for wellbeing at work than objective practical support. This is consistent with findings from other studies on objective workplace conditions: objective workplace conditions are not related to perceived mental health problems [18]. An explanation can be the inter-individual differences in subjective perception of these objective conditions. However, this finding shows that a differentiation of different aspects of social support – practical, emotional, interactional – is useful.

Limitations of the study and implications for further research

This is a cross-sectional exploratory study. It does not allow causal interpretations concerning the relation between job-anxiety and social support.

Additional variables such as personality styles, which could have an influence on the perception of social support and symptom load, have not been investigated in this study. For a better understanding of the complex interactions that are potentially associated with the course of job-anxiety, variables such as personality, mental and somatic health status, actual work characteristics, implicit social supportive resources and so on would be important. To

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gain and interpret such a complex set of information, case management studies could be done in the context of vocational reintegration management.

Here a clinical sample was investigated. Further research will investigate other clinical and non-clinical populations concerning perceived symptom load and social support.

Due to the context of investigation, it was not possible to conduct workplace analyses, which would be necessary to gain objective information of the participants' current work situations.

In the future, investigations focusing on the influence of different professional settings are needed. This could be done by investigating people from originally "social" professions [41] and comparing them to people working in manufacturing or production domains, or other workplaces where less social interaction takes place.

In further research, also differentiation between colleagues and superiors as potential sources of social support at work could be done. This would help to find out whether colleagues or superiors are more or less strongly related with job-anxiety.

Implications for the clinical and rehabilitation practice

In the treatment of patients with psychosomatic and psychiatric disorders, it seems worth to ask about specific work-related mental health problems and related problems of social support.

In cases where workplace problems are obvious, work-related therapeutic interventions are indicated [22]. In cases of job-anxiety related with social conflicts and low perceived social support at work, specific interventions could focus on improving the patient's interactional competencies or interactional performance, or conflict management competencies [28].

Conclusion

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Job-anxiety is a specific mental problem and different from general psychosomatic symptom load. Job-anxiety cannot be subsumed in a concept of general psychosomatic symptom load, but must be investigated separately and addressed specifically. Social support as a correlate of mental problems seems to be more relevant for job-anxiety than for general psychosomatic symptom load. However, the specific job-related social support must be addressed.

The findings from this study can be interpreted as evidence for the validity of job-anxiety and social support at work as domain-specific phenomena.

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Table 1. Job-related and conventional psychopathology, job-related participation disorders and perceived social support in working psychosomatic inpatients (*N*=154). Means (standard deviation) or percentages of occurrence are reported. *P*-values are reported for determining significance of difference between the groups.

[a] patients with low job-anxiety (0-0.9) versus patients with moderate job-anxiety (1-1.9)
[b] patients with moderate job-anxiety (1-1.9) versus patients with higher job-anxiety (2-2.9)
[c] patients with higher job-anxiety (2-2.9) versus patients with strongest job-anxiety (3-4)
[d] patients with low job-anxiety (0-0.9) versus patients with strongest job-anxiety (3-4)

Groups of patients with JAS mean scores	**0-0.9 Low job-anx. (N=60)**	**1-1.9 Moderate job-anx. (N=46)**	**2-2.9 Higher job-anx. (N=29)**	**3-4 Strongest job-anx. (N=19)**	**Significance of difference** *p*
Work Participation					
Currently on sick leave at the time of admission	12%	30%	66%	84%	[a] .122 [b] .002** [c] .738 [d] .000**
Duration of current sick leave before admission in weeks	1,47 (5.0)	8,07 (15.6)	18,0 (23.0)	26,47 (30.0)	[a] 1.297 [b] .098 [c] .560 [d] .000**
Duration of sick leave in the past 12 months in weeks	5,73 (5.8)	9,93 (12.9)	18,83 (16.7)	27,84 (14.2)	[a] .488 [b] .015** [c] .081 [d] .000**
.000** [b] .340 [c] .009**					
[d] .000**					
Dimensions of Social Support					
Household: Practical support	2.40 (1.2)	2.61 (1.1)	2.92 (1.1)	2.33 (0.8)	[a] 1.000 [b] 1.000 [c] .692 [d] 1.000
Household: consolation and encouragement	2.62 (1.2)	2.64 (1.1)	2.58 (1.0)	2.71 (0.9)	[a] 1.000 [b] 1.000 [c] 1.000 [d] 1.000
Household: criticism, overload, rejection	1.18 (1.1)	1.31 (0.8)	1.13 (0.8)	1.14 (0.8)	[a] 1.000 [b] 1.000 [c] 1.000 [d] 1.000
Wider family: Practical support	2.38 (1.3)	2.11 (1.3)	2.42 (1.2)	2.29 (0.8)	[a] 1.000 [b] 1.000 [c] 1.000 [d] 1.000
Wider family: consolation and encouragement	2.81 (1.0)	2.40 (1.2)	2.30 (1.3)	2.43 (1.2)	[a] .514 [b] 1.000 [c] 1.000 [d] 1.000
Wider family: criticism, overload, rejection	0.79 (1.0)	1.38 (1.2)	1.26 (1.1)	0.93 (1.2)	[a] .066 [b] 1.000 [c] 1.000 [d] 1.000
Colleagues at work: Practical support	2.35 (1.2)	1.88 (0.9)	1.35 (1.0)	0.87 (0.9)	[a] .194 [b] .312 [c] 1.000 [d] .000**
Colleagues at work: consolation and encouragement	2.43 (1.0)	1.69 (1.0)	1.30 (1.1)	0.67 (0.6)	[a] .002** [b] .806

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	[c] .324
	[d] .000**

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Colleagues at work: criticism, overload, rejection	0.64 (0.8)	1.36 (1.1)	1.83 (1.2)	2.27 (1.1)	[a] .003** [b] .382 [c] 1.000 [d] .000**
Friends: Practical support	2.21 (1.2)	2.10 (1.0)	1.96 (1.4)	1.81 (1.1)	[a] 1.000 [b] 1.000 [c] 1.000 [d] 1.000
Friends consolation and encouragement	2.89 (0.9)	2.54 (1.0)	2.68 (1.2)	2.13 (1.0)	[a] .506 [b] 1.000 [c] .548 [d] .045**
Friends: criticism, overload, rejection	0.34 (0.6)	0.49 (0.6)	0.82 (0.8)	0.69 (0.8)	[a] 1.000 [b] .395 [c] 1.000 [d] .424
Leisure time contacts: Practical support	2.0 (1.3)	1.58 (1.1)	1.44 (1.5)	1.50 (1.0)	[a] 1.000 [b] 1.000 [c] 1.000 [d] 1.000
Leisure time contacts: consolation and encouragement	2.14 (1.0)	1.64 (0.9)	2.10 (1.0)	1.56 (1.1)	[a] .353 [b] 1.000 [c] 1.000 [d] .724
Leisure time contacts: criticism, overload, rejection	0.42 (0.8)	0.48 (0.8)	0.40 (0.5)	0.89 (0.8)	[a] 1.000 [b] 1.000 [c] .947 [d] .561
Neighbors: Practical support	1.96 (1.3)	1.62 (1.2)	1.50 (1.5)	1.80 (1.3)	[a] 1.000 [b] 1.000 [c] 1.000 [d] 1.000
Neighbors: consolation and encouragement	1.81 (1.3)	1.52 (1.3)	1.17 (1.3)	1.73 (1.2)	[a] 1.000 [b] 1.000 [c] 1.000 [d] 1.000
Neighbors: criticism, overload, rejection	0.39 (0.9)	0.36 (0.6)	0.71 (0.9)	0.80 (0.9)	[a] 1.000 [b] .577 [c] 1.000 [d] .527

note: **p=<.05

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Table 2. The relations between job-anxiety (JAS), dimensions of perceived social support and general psychosomatic symptom load in working psychosomatic inpatients (*N*=154). Values reported are Pearson-correlations.

Measure	JAS mean	SCL-90-R GSI	JAS mean (SCL-90-R GSI controlled)	SCL-90-R GSI (JAS mean controlled)
Symptom Load				
JAS mean	1	.460**		
SCL-90-R GSI	.460**	1		
Dimensions of Social Support				
Household: Practical support	.049	-.099	.106	-.077
Household: consolation and encouragement	-.022	-.135	-.056	-.230
Household: criticism, overload, rejection	.000	.192	-.003	.171
Wider family: Practical support	-054	-.040	-.071	-.166
Wider family: consolation and encouragement	-.197*	-.093	-.263	-.150
Wider family: criticism, overload, rejection	.119	.278**	-.130	.232
Colleagues at work: Practical support	-.481**	-.321**	-.279	-.139
Colleagues at work: consolation and encouragement	-.572**	-.363**	-.587**	-.108
Colleagues at work: criticism, overload, rejection	.532**	.357**	.498**	.189
Friends: Practical support	-.148	-.165*	-.150	-.192
Friends consolation and encouragement	-.235**	-.239**	-.237	-.118
Friends: criticism, overload, rejection	.232**	.403**	-.195	.302*
Leisure time contacts: Practical support	-.220	-.135	-.134	-.220
Leisure time contacts: consolation and encouragement	-.187	-.202	-.089	-.182
Leisure time contacts: criticism, overload, rejection	.171	.369	.212	.242
Neighbors: Practical support	-.105	-.147	-.108	-.156
Neighbors: consolation and encouragement	-.126	-.172*	-.004	-.245
Neighbors: criticism, overload, rejection	.164	.271**	.008	.188

note: *p=<.05, **p=<.01

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